PHYSICAL FITNESS TEST REQUIREMENTS

Per Standards of N.H. Police Academy (N.H. Police Standards & Training Council)

Scores Required to Pass at 35th %-ile (Entrance to Corrections Academy)

AGE RANGE	ONE - REP BENCH PRESS Minimum % of Body weight to lift		PUSH - UPS Required number to complete		SIT - UPS Required number to complete (in 1		1.5 MILE TIMED RUN Required maximum minutes allowed	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
18-29	0.96	0.58	27	22	37	31	13:06	15:49
30-39	0.86	0.52	21	17	33	24	13:53	16:23
40-49	0.78	0.48	16	11	28	19	14:47	16:59
50-59	0.70	0.43	11	10	22	12	15:53	18:09

Scores Required to Pass at 45th %-ile (Graduation from Corrections Academy)

AGE RANGE	ONE - REP BENCH PRESS Minimum % of Body weight to lift		PUSH - UPS Required number to complete		SIT - UPS Required number to complete (in 1		1.5 MILE TIMED RUN Required maximum minutes allowed	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
18-29	1.03	0.63	31	25	39	34	12:20	15:10
30-39	0.90	0.55	25	20	36	26	13:22	15:47
40-49	0.82	0.51	19	14	30	21	14:08	16:34
50-59	0.73	0.45	14	13	25	16	15:08	17:29

Note: Correctional Officers, and Probation/Parole Officers will be **required** to pass the Physical Fitness Test in order to gain entrance in the Corrections Academy and to attain / maintain certification as Law Enforcement Officers.

Note: Other staff members who attend the Corrections Academy are **expected to participate, to the best of their ability.**

10-15-04

N. H. DEPARTMENT OF CORRECTIONS
Performance Standards & the Corrections Environment
Corrections Academy

PHYSICAL PERFORMANCE

Department of Corrections employees are required to complete the Corrections Academy held at Police Standards and Training. The following is an explanation of the various standards of performance, training components and requirements which are to be used in determining the capability of the applicant to participate in this program of instruction and work in the corrections environment.

Certified Officers:

Corrections Officers and Probation/Parole Officers are ***required to pass*** the physical fitness test and must be able to fully participate and successfully complete the physical training, unarmed self defense (defensive tactics) and weapons qualification components in order to be certified as a corrections officer under N. H. Police Standards & Training Council Rules.

Corrections Line Personnel:

Other D. O. C. employees are ***encouraged to participate to the best of their ability*** in the physical fitness test, unarmed self defense (defensive tactics) and physical training. Furthermore, they may participate in weapons familiarization rather than weapons qualification.

Self Defense

The following is a list of activities, movements, postures and positions that are included in the unarmed self defense (defensive tactics) and other classes conducted as part of the academy. Please note the implications to the musculo-skeletal system, especially stress to joints as this information is reviewed. Physical training also involves participating in "take down" techniques where the participants are "thrown" or fall down onto a mat. Finally, strenuous physical activities may increase the demand on the cardio-pulmonary and vascular systems causing increased heart rate, respiratory rate, and blood pressure.

bending	crouching	jabbing	lifting	punching	restraining	stretching
blocking	falling	jumping	marching	pushing	running	swinging
chopping	grasping	kicking	pivoting	reaching	spinning	thrusting
crawling	gripping	kneeling	pulling	resisting	squatting	twisting

Incident Control: Oleoresin Capsicum (OC)

Oleoresin Capsicum (OC) is an agent used to subdue out-of-control inmates during altercations and disturbances. The components are comprised of an essential oil and a resin found in nature (oleoresin) and the active ingredient, which is a derivative of cayenne pepper (capsaicin). Departmental staff members are instructed in the safe handling of this agent and techniques to administer the agent to control volatile situations. This training is initiated in the Corrections Academy and as part of ongoing In-service Education programming. Students are exposed to OC by primary contact, such as aerosolized droplets or foam, and by secondary contact by handling objects contaminated by the agent. They are also taught how to properly treat areas that may have been exposed to the agent.

CORRECTIONS ENVIRONMENT

The Corrections environment is an environment where N. H. Department of Corrections staff members are in direct/close contact with convicted felons or psychiatric patients who may have a history of unpredictable or violent behavior; this requires the ability to maintain vigilance, the utilization of well developed observation skills and the capacity to respond rapidly to unexpected and/or emergency situations.

Other physical demands may include periods of prolonged standing, walking, or sitting, and occasional to frequent stair climbing.

N. H. DEPARTMENT OF CORRECTIONS
BUREAU OF HUMAN RESOURCES
OFFICE OF EMPLOYEE HEALTH SERVICES

Contents: Pre-assignment Physical Examination Packet

1. Physical Examination Menu
2. Release of Medical Information form
3. Instructions for the Completion and Distribution of Medical Evaluation Paperwork
5. Medical History form (three (3) pages)
6. Physical Examination form (three (3) pages)
7. Occupational Health Form
7. Pass for entry into a Department of Corrections facility
8. TB Screening / Immunization form
9. Medical Follow-up form
10. Audiology Recourse Testing form

Questions should be directed to your recruiter or Employee Health Services.

N. H. DEPARTMENT OF CORRECTIONS
BUREAU OF HUMAN RESOURCES
OFFICE OF EMPLOYEE HEALTH SERVICES

Physical Examination Menu

Name: _____

Position: _____

____ Physical Examination

____ Audiology Screening (for Officers only)

____ TB Screening: ☐ Mantoux (PPD) ☐ Symptom Check

____ Urinalysis by dipstick

N. H. DEPARTMENT OF CORRECTIONS
BUREAU OF HUMAN RESOURCES
OFFICE OF EMPLOYEE HEALTH SERVICES

RELEASE OF MEDICAL INFORMATION

I authorize the N. H. Department of Corrections to provide copies of any or all records or reports resulting from my pre-assignment physical evaluation to include my medical history and physical examination, the results of laboratory or other tests (which may include third party disclosure), physician statements and the Occupational Health Form to the Staff of N. H. Police Standards and Training Council as part of application for enrollment in the Department of Corrections Academy.

Name	Signature	Date

Witness Name	Witness Signature	Date

N. H. DEPARTMENT OF CORRECTIONS
BUREAU OF HUMAN RESOURCES
OFFICE OF EMPLOYEE HEALTH SERVICES

Instructions for Completion and Distribution of Medical Evaluation Paperwork

YOU ARE RESPONSIBLE FOR FOLLOWING THESE DIRECTIONS AND INSTRUCTIONS

1. The forms in this packet must be completed **prior** to reporting to your appointment.
2. Responses **must be printed legibly** in blue or black ink using a **ball point pen**.
3. **DO NOT LEAVE ANY BLANK LINES OR SPACES**
4. Be sure that your **full name** and date of birth (DOB) are recorded in the spaces provided **on each page.**
5. If you have any questions, please ask before you leave for your appointment.
6. If you wear corrective lenses YOU MUST HAVE THEM WITH YOU for your appointment.

   NOTE: If you wear contact lens you will be required to remove them for the examination. Please bring any necessary supplies with you to the appointment.

7. Medical History
   - Page 1
     - Item 4 Home address: be sure to include city or town and state
     - Item 5 Home phone: You **may also** include a work phone or cell phone
     - Item 6 Position: indicate the Position for which you are applying
     - Item 7 Purpose of Examination: indicate "Pre-assignment Physical Exam"
     - Item 10 Indicate any current medical conditions; write the names of **all** medications to include "over the counter" (OTC) , herbal or dietary supplements
   - Page 2
     - Items 17 through 26: If any of these categories are answered "yes" a detailed explanation is required; use the space to the right. PLEASE USE THE APPROPRIATE CORRESPONDING NUMBER TO LABEL EACH EXPLANATION
   - Page 3
     - Item 25: Read carefully and sign to confirm that your answers are accurate and complete
8. Occupational Health Form

   You will be given the Occupational Health form by the examiner at the end of your appointment. You must retain this form and present it to the instructor on the day of your Physical Fitness Test.

   NOTE: YOU WILL NOT BE PERMITTED TO TAKE THE PT TEST WITHOUT THIS FORM
9. TB Screening/Immunization Record and Pass

   You will be given your TB Screening/Immunization Record and a Pass to admit you to one of the DOC facilities to have the TB Test read.

   NOTE: Reading of the screening test is TIME SENSITIVE. If you fail to meet the time requirements the test is invalid. This screening is required for medical clearance.

   Please return the completed TB form to EMPLOYEE HEALTH SERVICES OFFICE as soon as possible after the test is read.

   MEDICAL CLEARANCE CANNOT BE COMPLETED WITHOUT IT

   Mailing address:
   PO Box 1806
   Concord, NH 03302-1806

   Street address:
   105 Pleasant St., 3rd Floor
   Concord, NH 03301
10. Information recorded on these documents is for official use only in order to determine if your health status will allow you to perform the duties required for the position for which you have applied.

Questions should be directed to your recruiter or N. H. Department of Corrections Employee Health Services.

N. H. Department of Corrections
Employee Health Services
Medical History

1. Last Name	First Name	Middle Name	2. Date of birth:	3. Social Security Number:

4. Home Address	5. Home Phone:	6. Position:

7. Purpose of Examination	8. Examination Date	9. Facility Name and Address

10. State of Your Current Health and Medications (Follow with description of past history if complaint or condition still exists)

Medications and date of last dose: (Prescription or OTC)

11. Have you ever (Please check each Item)

YES	NO	
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

12. Do you: (Please check each item)

YES	NO	
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear any type of brace or other skin of support

13. **Have you ever had or do you now have:** (Please check to the left of each condition listed below)

YES	NO	Unknown	Condition or Symptom
			Scarlet Fever, erysipelas
			Rheumatic fever
			Swollen or painful joints
			Frequent or severe headaches
			Dizziness or Fainting spells
			Eye trouble
			Ear or Nose or Throat trouble
			Hearing loss
			Chronic or frequent colds
			Sever tooth or gum trouble
			Sinusitis
			Hay fever
			Skin disease
			Thyroid trouble
			Tuberculosis
			Asthma
			Shortness of breath
			Pain or pressure in chest
			Chronic cough
			Palpitation or pounding heart
			Heart trouble
			High or low Blood Pressure
			Cramps in your legs
			Stomach/Liver/Intestinal trouble
			Gall bladder trouble or gall stones
			Jaundice or Hepatitis
			Adverse reaction to serum or drugs
			Have allergies of any kind

List of allergies:

YES	NO	Unknown	Condition or Symptom
			Broken bones
			Tumor or growth of Cancer
			Rupture or hernia
			Piles or Rectal disease
			Frequent or painful urination
			Bedwetting since 12 years old
			Kidney stone or blood in urine
			Sugar or albumin in urine
			STD: syphilis, gonorrhea, chlamidia, etc
			Recent gain or loss of weight
			Arthritis, rheumatism or bursitis
			Bone or joint or other deformity
			Lameness
			Loss of a finger or toe
			Painful or "trick" shoulder or elbow
			Recurrent back pain
			"Trick" or locked knee
			Foot trouble
			Neuritis
			Paralysis (including infantile)
			Epilepsy / convulsions / seizures
			Car or sea or air sickness
			Frequent trouble sleeping
			Depression or excessive worry
			Nervous trouble of any sort
			Periods of unconsciousness

14. **For females only**---Have you ever:

YES	NO	Unknown	Condition or Symptom
			Been treated for a menstrual disorder
			Had a change in menstrual pattern

Date of last menstrual period:

N. H. Department of Corrections
Employee Health Services
Medical History

Name: _____

DOB: _____

15. What is your usual occupation:	16. Are you (circle one) Right handed Left handed

Check each item yes or no. Every item checked yes must be fully explained in the blank space provided on the right.

YES	NO	CATEGORY	EXPLANATION
		17. Have you been refused employment or been unable to hold a job or stay in school because of: ___A. Sensitivity to chemicals, dust, sunlight, etc. ___B. Inability to perform certain motions. ___C. Inability to assume certain positions. ___D. Other medical reasons (If yes, give reasons)	
		18. Have you ever been treated for a mental condition? If yes, specify when, where, and give details.	
		19. Have you ever been denied life insurance? If yes, state the reason and give details.	
		20. Have you had or have you been advised to have any operations? If yes describe and give age at which they occurred.	
		21. Have you ever been a patient in any type of hospitals? If yes specify when, where why and the name of doctor and complete address of hospital.	
		22. Have you ever had any illness or injury other than those already noted? If yes, specify when, where, and give details.	
		23. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past 5 years for other than minor illnesses? If yes give complete address of doctor, hospital, clinic and details.	
		24. Have you ever been rejected for military service because of physical, mental or other reasons? If yes give date and reason for rejection.	
		25. Have you ever been discharged from military service because of physical, mental or other reasons? If yes, give date, reason, and type of discharge: Honorable, Other than Honorable, for Unfitness, or Unsuitability.	
		26. Have you ever received, is there pending, or have you applied for pension or compensation for an existing disability? If yes, specify what kind, granted by whom, what amount, when and why?	

N. H. Department of Corrections
Employee Health Services
Medical History

Name: _____

DOB: _____

27. I attest the information I have provided on the Report of Medical history form is complete and true to the best of my knowledge. I realize that deliberate falsification constitutes fraud for which the law (N. H. RSA 638) provides penalties. Furthermore, I understand that such falsification will disqualify me from further consideration and should I be employed, may result in disciplinary action to include dismissal.

Printed name of Examinee	Signature	Date

28. Physician's summary and elaboration of all pertinent data. **The examiner must comment on all positive answers in items 11 through 24.** The examiner may develop any additional medical history deemed important by interview with examinee and record significant findings below.

Item #	Comments

Typed or printed name and address of examiner	Examiner's signature	
Name _____ Address _____ _____	Phone number FAX number	Date signed

➔ **Return to: Lisa Angelini, RN / CNA, BC Administrator, Employee Health Services**

FAX (603)271-3345

Phone (603) 271-5661
E-Mail: langelini@nhdoc.state.nh.u

NH Department of Corrections
Employee Health Services
PO Box 1806
Concord, NH 03302-1806

N. H. Department of Corrections
Employee Health Services
Physical Examination

1. Last Name	First Name	Middle Initial	2. Date of Birth

3. General Appearance and Development (Circle one) Good Fair Poor	4. Position Circle one Group I Group II
5. Height without shoes / 6. Weight without shoes	

7. Visual Acuity

Note: If applicant wears glasses or contact lenses, test and record results with and without

a. Distant	Without accommodation	R/20 _____	L/20 _____	B/20 _____
	With accommodation	R/20 _____	L/20 _____	B/20 _____
b. Near	Without accommodation	R/20 _____	L/20 _____	B/20 _____
	With accommodation	R/20 _____	L/20 _____	B/20 _____

c. Depth perception: _____ d. Color perception: _____

e. Form Fields of vision: Left Eye:_____ Right Eye:_____ Each on Zero Line:_____

Circle one: Degrees of fields obtained by instrumentation or confrontation.

8. Eyes

a. Pupils: Shape:_____ Equal:_____ Reaction:_____

b. Evidence of disease or injury: _____ c. Fundoscopic: _____

9. Head and Neck

a. Nose: _____ b. Septum: _____ c. Teeth: _____ d. Gums: _____

e. Pharynx: _____ f. Tonsils: _____ g. Soft Tissue: _____

h. Thyroid: _____ i. Bruit: _____ j. Nodes: _____

k. Ears: _____ l. Tympanic Membranes: Left _____ Right _____

10. Hearing

Indicate testing method / instrument used:

Right Ear:	500 Hz _____	1000 Hz _____	2000 Hz _____	3000 Hz _____
Left Ear:	500 Hz _____	1000 Hz _____	2000 Hz _____	3000 Hz _____

11. Chest

a. Configuration _____ b. Measurement: Inspiration: _____

c. Axillary Nodes _____ Expiration: _____

12. Lungs

a. Breath Sounds _____ b. Rales: _____ c. Rub: _____

13. Heart

a. Rate: _____ b. Rhythm: _____ c. Sounds _____

14. Cardio-Vascular

	Activity	Blood Pressure	Pulse Rate	Heart Sounds	Rhythm
a.	At rest				
b.	After moderate exercise				
c.	3 minutes post exercise				

Type and duration of exercise used for testing: _____

Explain significance of BP measurements above 145 Hg systolic or 95 Hg diastolic in item # 21.

	Circulation to extremities	Pulses	Color	Temperature	Edema
d.	Left hand / radial				
e.	Right hand / radial				
f.	Left foot / pedal				
g.	Right foot / pedal				

h. **Note any abnormalities:** _____

N. H. Department of Corrections
Employee Health Services
Physical Examination

Name: _____

DOB: _____

15. Abdomen

a. Girth: _____ b. Scars: _____ c. Bowel sounds: _____
d. Palpation: _____ e. Liver: _____ f. Spleen: _____
g. Kidneys: _____ h. Genitalia: _____ i. Hernia: _____

16. Rectal

THIS EXAM IS RECOMMENDED FOR INDIVIDUALS 40 Y.O. AND OLDER BUT **IS NOT REQUIRED**

a. Fissure: _____ b. Fistula: _____ c. Hemorrhoids: _____

17. Musculo-skeletal

Test by bending, stooping, R.O.M. of upper and lower extremities and digits.

	Body Part	Posture	Mobility	Symmetry	Function	Pain	Missing Parts
a.	Neck						
b.	Upper left						
c.	Upper right						
d.	Lower left						
e.	Lower right						
f.	Spine						

18. Nervous System

a. Rhomberg: _____ b. Pupillary: Left: _____ Right: _____

c.

Tendon Reflexes	Brachial	Radial	Patellar	Achilles	Plantar
Left side					
Right side					

19. Labs & Diagnostics

a. Urinalysis: Specific gravity: _____ Albumin: _____ Glucose: _____ Micro: _____
b. Bloodwork: Hematocrit: _____ **PRN:** EKG: _____ CXR: _____

20. Special Considerations

a. Are there any conditions, physical, mental or emotional which suggest further testing or examination?

☐ Yes ☐ No **Explain all positive responses in Item # 22**

b. Do you have any reservations about this individual's ability to participate in Physical Fitness Testing or ability to perform actions and assume postures of Physical Performance Standards?

☐ Yes ☐ No **Explain all positive responses in Item # 21**

21. Remarks

Explanation of the significance or impact of all positive clinical findings:

Item # Remarks & Recommendations:

N. H. Department of Corrections
Employee Health Services
Physical Examination

Name: _____

DOB: _____

22. Conclusion	Certification of Medical Release: Upon review of the Medical Standards of the NH Police Standards & Training Council as well as the Physical Performance Standards of the NH Department of Corrections, this certifies that the above named individual was examined by me on _____ ☐ is in good health and is able to participate in the NH Department of Corrections Academy and the Physical Training Program ☐ Without restriction(s) or limitation(s). ☐ With the restriction(s) or limitation(s) of: _____ _____ _____ _____ _____ _____ _____ ☐ is subject to further medical assessment by for the following reasons: _____ _____ _____ _____ _____ _____ _____ ☐ He /she has been given: a Medical Follow-up Notice ☐ Yes ☐ No ☐ N / A an audiology recourse testing packet ☐ Yes ☐ No ☐ N / A a copy of Medical History & Physical Examination ☐ Yes ☐ No ☐ N / A Other: _____

23. Examiner Identification and Signature	Typed or printed name and address of examiner Name _____ Address: _____ _____	Examiner's signature	
		Phone number	Date signed
		FAX number	

Return to: **Lisa Angelini, RN / CNA, BC**

FAX (603) 271-3345

Phone (603) 271-5661
E-Mail langelini@nhdoc.state.nh.us

NH Department of Corrections
Employee Health Services
PO Box 1806
Concord, NH 03302-1806

STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
Human Resources Bureau
P. O. Box 1806
Concord, New Hampshire 03302-1806
FAX: (603) 271-3345

Lisa Currier
Administrator

Memorandum

(Pass for Entry into Depart. Of Corrections facility)

To: **FRONT DOOR OFFICER** Date _____

From: Rod Greenwood
Recruiting Lieutenant

At: NH DOC Recruiting Office
Phone: 271-5645

Subject: **Reading of TB Screening Test**

This perspective employee _____ needs to have his / her TB test read at:

____ NHSP-Men, Health Services Center in Concord
Phone: 271-1853 or 271-6064

____ NHSP-Women, Health Services Center in Goffstown
Phone: 668-6137, ext 311 or 312

____ Lakes Region Facility, Health Services Center in Laconia
Phone: 528-9200 Location is Station L

____ Northern NH Correctional Facility, Health Services Center in Berlin
Phone: 572-0345

____ DOC Headquarters, Employee Health Services Office in Concord
Phone: 271-5661

Instructions to Applicant: Report to the above facility

AFTER _____ ON _____
BEFORE _____ ON _____
} **(24 hour window)**

READING OF RESULTS **MUST** BE DONE **AFTER** 48 HOURS
BUT
NO LATER THAN 72 HOURS

REMINDER: **Please return the completed TB form to**
EMPLOYEE HEALTH SERVICES OFFICE
as soon as possible
MEDICAL CLEARANCE CANNOT BE COMPLETED WITHOUT IT.

N. H. Department of Corrections
Employee Health Services
TB Screening / Immunization Record

Name: ______________________

DOB: __________

History

Allergies: ____

TB skin test reaction
- ☐ Unknown
- ☐ Negative __________
- ☐ Positive __________

Last Chest X-Ray
Date: __________
Result: ______________

Previous TB Treatment Dates: from __________ to __________
Meds: ____

Active TB Treatment Dates: from __________ to __________
Meds: ____

BCG vaccination Date: __________
Reason: ____

TB Screening (Mantoux)

TB Control Type	Date Adm.	by Nurse	Site	Lot #	Date Read	by Nurse	Result

Other Vaccines or Screening Tests

Description (Type of Vaccine or Test)	Date Adm.	by Nurse	Site	Lot #	Comments

T. B. Symptom Check and History

Date	HCP: __________ CXR Date: ________ Results: ________ Comments: ________ Productive Cough Y N Hemoptysis Y N Weight loss Y N Chronic resp. symptom Y N Night sweats Y N
Date	HCP: __________ CXR Date: ________ Results: ________ Comments: ________ Productive Cough Y N Hemoptysis Y N Weight loss Y N Chronic resp. symptom Y N Night sweats Y N
Date	HCP: __________ CXR Date: ________ Results: ________ Comments: ________ Productive Cough Y N Hemoptysis Y N Weight loss Y N Chronic resp. symptom Y N Night sweats Y N
Date	HCP: __________ CXR Date: ________ Results: ________ Comments: ________ Productive Cough Y N Hemoptysis Y N Weight loss Y N Chronic resp. symptom Y N Night sweats Y N
Date	HCP: __________ CXR Date: ________ Results: ________ Comments: ________ Productive Cough Y N Hemoptysis Y N Weight loss Y N Chronic resp. symptom Y N Night sweats Y N

N. H. Department of Corrections
Employee Health Services

Name: _____

Occupational Health Form

DOB: _____ wgt: _____

Physical Training Program Requirements of Corrections Academy

Training Program

Activity/Motion	Yes	No
Run	___	___
Sit-ups	___	___
Push-ups	___	___
Climb	___	___
Reach	___	___
Grasp	___	___
Push	___	___
Pull	___	___
Strike/punch	___	___
Jump	___	___
Twist	___	___
Lunge	___	___
Pivot	___	___
Squat	___	___
Kneel	___	___
Bend	___	___
Crawl	___	___
Kick	___	___
Fall to ground	___	___
Restrain another person	___	___

Physical Fitness Test

SIT - UPS (*in 60 seconds*)

Number to complete		
AGE	MALES	FEMALES
18-29	37	31
30-39	33	24
40-49	28	19
50-59	22	12
60+	18	5

PUSH - UPS

Number to complete		
AGE	MALES	FEMALES
18-29	27	22
30-39	21	17
40-49	16	11
50-59	11	10
60+	9	4

1.5 MILE TIMED RUN

Minutes to complete		
AGE	MALES	FEMALES
18-29	13:06	15:49
30-39	13:53	16:23
40-49	14:47	16:59
50-59	15:53	18:09
60+	16:59	18:54

ONE-REPETITION BENCH PRESS

Weight requirement*		
AGE	MALES	FEMALES
18-29	0.96	0.58
30-39	0.86	0.52
40-49	0.78	0.48
50-59	0.70	0.43
60+	0.65	0.41
* Multiply by body weight		

Bench press wgt: _____ lbs

1. ___ Is able to fully participate in the Physical Training Program and Physical Fitness Testing as indicated above

2. ___ Is able to participate in the Physical Training Program and Physical Fitness Testing with the following restrictions:

_____

_____

_____

3. Recommendations/Instructions/Referrals:

_____

_____

_____

_____ _____ _____

(HCP Signature) (Patient's Signature) (Date)

cc: Patient
DOC EHS

N. H. Department of Corrections
Employee Health Services

Medical Follow-up Notice

Name: _____

DOB: _____

Your pre-assignment medical examination / laboratory / screening tests conducted for the N. H. Department of Corrections requires:

___ Follow-up by your personal Health Care Provider

___ Input / clarification from your personal Health Care Provider

___ Further clinical evaluation and/or treatment for concerns or conditions noted below:

_____

_____

_____

_____

_____

_____

_____

Clinical findings that warrant attention include:

___ Laboratory results outside the normal range

___ Clinical findings that do not meet NH Police Standards & Training Council Medical Standards

___ Recent medical condition/history that does not meet NH Police Standards & Training Council Medical Standards

___ Other: _____

_____ _____

Date HCP Signature

PLEASE NOTE:

You **MUST** contact Lisa Angelini, RN/CNA, BC before you proceed with any follow-up activities indicated above. Failure to do so will result in delays in the hiring process.

Lisa Angelini, Administrator, Employee Health Services
Phone: (603) 271-5661

CC: NH DOC Employee Health Services
File

STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
Human Resources Bureau
P. O. Box 1806
Concord, New Hampshire 03302-1806
FAX: (603) 271-3345

Lisa Currier
Administrator

Audiology Referral Memorandum

To: _____ Date _____

From: Lisa Angelini, RN/CNA, BC
Administrator, Employee Health Services

At: NH DOC Employee Health Services
Phone: 271-5661

Subject: **Recourse Testing/evaluation and correction**

The results of the audiology screening performed as part of your pre-assignment physical examination indicate that you have not met the standards established by the Police Standards and Training Council. As you were previously informed , passing the physical examination is one of the mandatory requirements for the position which you applied for. Therefore, the following steps must be taken for you to pass the physical and meet the established standards.

1. Notify your DOC recruiter **within five (5) days of the receipt of this notice** to confirm your intent to continue with the hiring process.

2. Make an appointment with a licensed audiologist for recourse testing. There are specific examination requirements which are outlined in the attachment. **Be sure to give this attachment to the audiologist at the time of your examination.** Should either of you have any questions or concerns about the process please call The Administrator of Employee Health Services for clarification.

3. Have the audiologist submit the results of the examination directly to the Administrator of Employee Health Services at the address at the top of this memorandum. Results may also be faxed to the number indicated above, but the original document must also be mailed to the address at the top of this memorandum.

4. Once the results are reviewed you shall be notified as to whether or not you have met the medical standard.

5. **PLEASE NOTE: This testing will not be paid for by the N. H. Department of Corrections; it will be at your own expense.**

6. If we do not hear from you in the time frame specified above we will conclude that you are no longer interested in pursuing employment with the Department of Corrections.

cc: L. Angelini, RN/CNA, BC

N. H. DEPARTMENT OF CORRECTIONS
BUREAU OF HUMAN RESOURCES
OFFICE OF EMPLOYEE HEALTH SERVICES

Recourse Testing: Audiology Requirements (per N.H. Police Standards and Training Council)

1. **Audiological examination**

   Administered by a licensed audiologist performed in a sound treated environment meeting the 1969 ANSI or any subsequent standard and is to include:

   - ***Hearing sensitivity***

   - ***Speech discrimination in quiet conditions***
     The CID W-22 word list should be presented at 50 DB HL via a calibrated speech audiometer through a single speaker stationed at zero degrees azimuth with the candidate seated at approximately one meter (39 inches) from the speaker.

   - ***Speech discrimination in noisy conditions***
     Speech (hearing) discrimination testing in a background of broadband noise shall be conducted in the same sound field environment. Using a different version of one of the CID W-22 word lists presented at 50 DB HL, a competing noise should be simultaneously presented at 40 DB HL (S/N ± 10) through the same speaker (zero degrees azimuth) as the test words or through a separate speaker located at 180 degrees azimuth.

→ **NOTE: An open-test response format must be utilized with the candidate responding in writing.**

2. **Hearing Aid Suitability**

   - ***Biological (HAC-B)***
     Use of hearing aids to achieve standards are permitted as long as they are self-contained and fit within (auricular) or behind/over (post auricular) the ear.

   and

   - ***Acoustical (HAC-A)***
     Candidates with hearing aids shall provide evidence from a licensed audiologist, using functional gain or real ear measurements, that such aid(s) meet the stipulated manufacturer's standards and have automatic shutdown capabilities.

Please document test results as percentages.

Questions should be directed to L. Angelini, RN/CNA, BC (603) 271-5661

N. H. DEPARTMENT OF CORRECTIONS

OFFICE OF EMPLOYEE HEALTH SERVICES

Hepatitis B Vaccine Administration: Informed Consent/Refusal

Name: _____ DOB: _____ Height: _____ Weight: _____

ALLERGIES: _____

I have received written information about Hepatitis B and the Energix-B vaccine. I have had an opportunity to ask questions, and I understand the risks and benefits of receiving the vaccine.

SECTION I Informed Consent

I request to receive the Energix-B vaccine. I understand that I must receive all three (3) doses in order to confer immunity. I understand that immunity is not guaranteed. I understand that I may experience any of the side-effects from the vaccine. I understand that my right to receive all three (3) doses depends on my continued employment with the NH Department of Corrections.

Employee Name	Employee Signature	Date
_____	_____	_____

SECTION II Vaccination Record

	Vaccine	Site	Lot #	Date	Administered by:
#1	_____	_____	_____	_____	_____
#2	_____	_____	_____	_____	_____
#3	_____	_____	_____	_____	_____

SECTION III Informed Refusal

I understand that due to an occupational exposure to blood or other body fluids contaminated with blood, I may be at risk for acquiring Hepatitis B infection. I have been given the opportunity to receive Hepatitis B vaccination at no cost to myself. Despite the risks of exposure and possible infection, I decline the vaccination at this time. If, in the future, I remain in an occupation where there is a potential for exposure to blood or body fluids contaminated with blood, I understand that I may choose to be vaccinated at that time at no cost to myself.

Employee Name	Employee Signature	Date
_____	_____	_____